No. 2
I—2-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34118

FILED NOV 9 1943

Registration District No. 1942

Primary Registration District No. 1000

Registrar's No. 1180

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
621 North 9th
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community: 16 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Buchanan

(c) City or town: St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 621 North 9th
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: LOWELL F. CHESNUT

3. (b) If veteran, name war: none

3. (c) Social Security No.: none

4. Sex: male

5. Color or race: white

6. (a) Single, widowed, married, divorced: single

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: April (Month) 8 (Day) 1915 (Year)

8. AGE: Years 28 | Months 6 | Days 22 | If less than one day: hr. min.

9. Birthplace: Wallace (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Invalid

11. Industry or business:

FATHER
12. Name: Alvie F. Chesnut
13. Birthplace: Buchanan county Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Grace E. Queen
15. Birthplace: Ashville (City, town, or county) N. Car. (State or foreign country)

16. (a) Informant: Mrs. Homer Farmer
(b) Address: St. Joseph, Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 11/ 2nd/43 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Auburn, Cemetery

18. (a) Signature of funeral director: Heaton Bethell & Bowman
(b) Address: 319 South 10th

19. (a) 10/30/43 (Date received local registrar) (b) Roe Skeyer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 30 year 1943 hour 12 minute 30 A M.

21. I hereby certify that I attended the deceased from Oct 6, 1943 to Oct 12 1943 that I last saw him alive on Oct. 11 1943 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pneumonia and Toxemia	10 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: none	
Of autopsy: none	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify):

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: E. M. S. Rhoes (M. D. or other) M.D.

Address 317 Kirkpatrick Bldg Date signed 10-30-43

1283

(Licensed Embalmer's Statement on Reverse Side) St. Joseph Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., ..., Registered Apprentice No. ....., working under my personal supervision.

Signed Frank A Bowman

Licensed Embalmer No. 1710

P. O. Address St Joseph Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.